

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
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Survey and Certification Voice/TTY (802) 241-0480

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Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 18, 2017

Ms. Allyson Sweeney, Administrator The Residence At Shelburne Bay East 185 Pine Haven Shores Road Shelburne, VT 05482-7805

Dear Ms. Sweeney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 27, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

amlaMlotaPN



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If continuation sheet 1 of 2

| Division of Licensing and Pr | otection | | | FORM APPROVED | |
|---|---|---|--|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) OATE SURVEY COMPLETED | |
| | 1009 | B. WING | | C 06/27/2017 | |
| NAME OF PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE, ZIP CODE | | 1 00/2//2017 | |
| THE RESIDENCE AT SHELBU | RNE BAY FAST 185 PINE | HAVEN SHO | RES ROAD | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CO PREFIX JEACH CDRRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY) | | V SHOULD BE COMPLETE | |
| R100 Initial Comments: | | R100 | | · | |
| An unannounced on site investigation of an anonymous complaint was conducted by the Division of Licensing and Protection on 6/27/17. The findings include the following: R251 VII. NUTRITION AND FOOD SERVICES SS=E 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that all food is stored to protect from all sources of contamination for 2 of 10 resident refrigerators inspected. The findings include the following: Per facility tour on 6/27/17 at 12:45 PM in the presence of the Executive Director, Resident Care Director and the Culinary Director, 2 resident refrigerators on the second floor were observed to contain 3 quarts of partially used spoiled/foul smelling curdled sour milk (with out dates of 6/13/17), unidentified food that was wrapped in paper napkins that was unable to be removed, an open container of cream cheese | | R251 | R251 Nutrition and Food Services 7.3 Food Storage and Equipment ACTION TAKEN TO CORRECT THE DEFICIENCY: The expired and spoiled milk, cream cheese, unidentified food, peanut butter, and roasted garlic hummus were discarded immediately. All resident refrigerators at Shelburne Bay East were checked for expired spoiled food/drink. All expired and spoiled food was discarded by the end of the day shift on 6/27/2017. MEASURES AND SYSTEMIC CHANGES WHICH WILL ENSURE THAT THE DEFI- CIENT PRACTICE DOES NOT RECUR: All resident refrigerators will be checked each week for expired/ spoiled food/beverage. Expired/ spoiled food and beverage will be discarded. Staff will be educated regarding the importance of maintaining proper food | | |
| with an expiration dat of Peanut Butter that 4/25/17 and an open Hummus with an exp Executive Director co the refrigerators are r contents or spoiled or | e of 6/17/17, an opened jar had an expiration date of container of Roasted Garlic iration date of 3/31/17. The offirmed during the tour that not monitored for food | THE RESIDENCE OF THE PROPERTY | importance of maintaining pro storage and equipment. | per food | |
| sion of Licensing and Protection ORATORY DIRECTOR'S OR PROVIDER | USUPPLIER REPRESENTATIVE'S SIGNA | TURE | TITLE | | |

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|---|--|--|---|-------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
| | 100 9 | B. WING | | | ; |
| NAME OF PROVIDER OR SUPPLIER | | <u> </u> | | 06/2 | 7/2017 |
| THE RESIDENCE AT SHELBU | | odress, city, s E HAVEN SHO f | | | |
| | SHELBL | IRNE, VT 0548 | 2 | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
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| | | | CORRECTIVE ACTIONS WILL BE MONITORED SUCH THAT THE DEFICIENT PRACTICE DOES NOT RECUR: | | |
| | | | The RCD will monitor refrigerators logs weekly x 4, and as needed to ensure compliance. | | |
| | | | All corrective action will be completed by August 2, 2017. | | |
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